

WETHRIVE COUNSELING CENTER CHILD/ADOLESCENT WELCOME PACKET

Confidential Patient Intake Information

Patient Full Name _____ Date _____

Date of Birth _____ Who referred you? _____ May we thank them? _____

Address _____ City _____ Zip _____

Mobile Phone _____ Would you like text reminders? Y N

Email _____ Would you like email reminders? Y N

Caregiver Full Name _____

Marital Status _____ Preferred Pronoun (circle one) He She They

Caregiver relationship to child

- Biological parent
- Other adult relative
- Foster parent
- Other _____

Are you the child's legal guardian? Y N

If joint custody or not legal guardian, please list other caregiver information: _____

Visitation schedule for child: _____

Who lives in the home with the child(ren)? _____

Emergency Contact Information:

Name: _____

Phone: _____

Relationship to child: _____

Has the child experienced any physical, sexual, or emotional abuse? Y N

If yes, please explain: _____

Has the child ever been to counseling before? Y N

If yes, please explain _____

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Has the child ever had a mental health diagnosis (e.g. depression, anxiety, ADHD) Y N

If yes, please explain _____

Is the child currently taking any medications? Y N If yes, please list _____

Has the child ever engaged in self-harm or any other self-destructive behaviors? Y N

If yes, please explain _____

Has the child ever talked about suicide? Y N

If yes, please explain _____

What is the reason for currently seeking therapy? _____

What do you want to achieve through therapy? _____

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Children's Brief Trauma Screen:

Infants and Toddlers ages 0-3

- Disruption of sleeping and toileting routines
- Startle response to loud/unusual noises
- "Freezing" (sudden immobility of body)
- Fussiness, excessive crying, and neediness
- Loss of acquired speech
- Loss of motor skills
- Separation fears and clinging to caregivers
- Withdrawal, lack of responsiveness
- Night terrors or nightmares

Children ages 3-18

- Upsetting thoughts or images about a stressful event, or re-enacting a stressful event in play
- Bad dreams related to a stressful event
- Acting, playing, or feelings as if a stressful event is happening right now
- Feeling very emotionally upset when reminded of a stressful event
- Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).
- Trying not to remember, talk about, or have feelings about a stressful event
- Avoiding activities, people, places, or things that are reminders of a stressful event
- (Ages 7+ only): Not being able to remember an important part of a stressful event
- (Ages 7+ only): Negative changes in how s/he thinks about self, others, or the world after a stressful event
- (Ages 7+ only): Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it
- Having very negative emotional states (afraid, angry, guilty, ashamed)
- Losing interest in activities s/he enjoyed before a stressful event. Including not playing as much
- Feeling distant or cut off from people around her/him
- Not showing or reduced positive feelings (being happy, having loving feelings)
- Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things
- (Ages 7+ only): Risky behavior or behavior that could be harmful
- Being overly alert or on guard
- Being jumpy or easily startles
- Problems with concentration
- Trouble falling or staying asleep

So glad you took this courageous step. We look forward to helping you!

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Understanding and Consent for Treatment

Therapy is not like a medical doctor visit; it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress.

Our policy for after-hours coverage is to leave a message and we will return your call as soon as possible. If you are in need of urgent or **emergency** services after hours, please **call COPES crisis line at (918) 744-4800 or 911.**

Please understand that information obtained from you is confidential. Information may not be shared with anyone without your permission except in the following circumstances:

1. When a court order is received.
2. When there is reasonable cause to believe that you will hurt yourself or someone else.
3. When there is reasonable suspicion to believe that abuse/ neglect of a child, elderly person or disabled person has occurred.
4. Information necessary for billing purposes to insurance companies.

WeThrive Counseling Center, its employees and contractors, utilizes various methods of communication to maintain contact with you including phone and email. We utilize text messaging in very limited circumstances and only for scheduling or basic informational purposes. No clinical information will be discussed via text message or email. If you attempt to discuss clinical matters you will be asked to call or wait until your next session to discuss.

Please be aware that electronic communication via telephone or email may not be secure for either party. Due to the nature of this type of communication, there is a potential for interception or misdirection of your information. Your use of phone or email to communicate protected health information indicates that you acknowledge and accept the possible risks associated with such communication. Please consider communicating any sensitive information in person to protect your privacy.

As a general rule, WeThrive Counseling Center, its employees and contractors, do not have contact with you outside of the office that is unrelated to mental health treatment. This rule applies to various Internet messaging sites, social networking sites and general emails unrelated to our professional relationship. Please understand that any contacts or requests for contacts will not be confirmed or acknowledged to protect your privacy as well as to eliminate a dual relationship.

Your **INITIALS** beside each of the following indicates your understanding and consent for treatment:

- _____ I understand that I may withdraw consent for treatment at any time
- _____ I have been offered a copy of HIPAA's Notice of Privacy Practices
- _____ I understand the risk associated with utilizing and electronic methods of communication and do so at my own risk
- _____ I understand I understand that email and texting will be utilized for scheduling
And incidental purposes only, private communication will be made in person

I hereby consent for WeThrive Counseling Center to provide treatment of the below named minor.

Patient Name: _____

Signature, Parent or Guardian

Date

Patient

Date

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STATEMENT OF FINANCIAL RESPONSIBILITY AND MISSED APPOINTMENT POLICY

Fees: Counseling sessions are at least 53 minutes long. We provide services at \$150 per session and the initial intake session \$200. Participation in legal proceedings is billed at \$200 per hour, including commute time, report writing, and other preparations. We ask that you put a credit card on file for billing.

Insurance: WeThrive will get an insurance quote from your insurance company before you start counseling. Please note, until we are paid by the insurance company the quote is sometimes incorrect and we will not know until the insurance company begins to pay us. Therefore, there may be some adjustments to your bill early on in treatment. We will also file your insurance for you. You will, however, be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company.

Charges: Payment, copays, co insurance and deductibles are due in full by cash, check or debit/credit card. You are responsible for these bills including any portion not covered or reimbursed by your insurance company.

Cancellation Policy: **Twelve hour notice is required for the cancellation of an appointment.** Appointments canceled with less than 12 hours notice will be **charged a \$100 fee** unless you are able to reschedule during the same week. Appointments missed because of inclement weather will not be charged. Your fee will be applied to your credit card on file. Understand it is your responsibility to maintain an **active and up to date credit card** on file to avoid any additional charges.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information	
Card Type:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX. <input type="checkbox"/> Other _____
Cardholder Name (as shown on card):	_____
Card Number:	_____ Security Code _____
Expiration Date (mm/yyyy):	_____ Cardholder ZIP Code _____

I authorize WeThrive Counseling to charge my credit card above for agreed upon services, as described above. I understand that my information will be saved to file for future transactions on my account.

Patient Signature

Date

Release of Medical Information

I authorize payment of insurance benefits to WeThrive Counseling, PLLC. I understand that I am financially responsible for any charges not covered by insurance or third party payer.

I authorize the release of any medical information necessary to process this claim. Oklahoma State Law (O.S. 63 Sec. 1-5022) requires the following statement: The information may include records which may indicate the presence of a communicable or venerable disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immune Deficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS).

Signature of Responsible Party: _____ Date: _____

Teletherapy Informed Consent Form

(1) “Teletherapy” includes consultation, treatment, emails, telephone conversations, and other medical information using interactive audio, video, or data communications. The platform WeThrive is utilizing is Clocktree and is HIPPA compliant.

(2) Teletherapy occurs in the state of Oklahoma (USA), and is governed by the laws of that state and the Board of Licensed Social Workers and the Board of Licensed Professional Counselors.

(3) The laws that protect the confidentiality of my (client) medical information also apply to teletherapy. Unless we (clinician and client) explicitly agree otherwise, our teletherapy exchange is confidential. Both parties will not include others in the session or have others in the room unless agreed upon.

(4) I (client) accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911, contact COPES with Family and Children’s Services (918-744-4800) or proceed to the nearest hospital emergency room for help.

(5) In the event our teletherapy is not in my (client) best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

(6) I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

I have read, understand, and agree to the information above. This consent is valid for one year from date signed.

Patient Name: _____

Signature, Parent or Guardian

Date

Patient

Date